

PATIENT ACQUAINTANCE INFORMATION

Patient's Name _____ Phone No. _____

Patient's Date of Birth _____ Patient's Social Security # _____

Patient's Address _____
Street # City, State Zip Code

Other Children in the family: (Are any of them patients of this practice) Yes No

Name _____ Age _____ Birthday _____
 _____ Age _____ Birthday _____

Patient's Pediatrician _____ Pediatrician's Phone Number _____

Parent's Dentist _____

Is Patient covered by dental insurance? No Yes or Medicaid Patient's Medicaid # _____

Child's Primary Insurance

Subscriber's Name _____
 Subscriber's Relation to Patient _____
 Subscriber # _____ DOB _____
 Employer _____
 Insurance Co: _____

(Street # Ins. Phone #)

(City, State) (Zip Code)
 Insurance ID#: _____ Group#: _____

Child's Secondary Insurance

Subscriber's Name _____
 Subscriber's Relation to Patient _____
 Subscriber # _____ DOB _____
 Employer _____
 Insurance Co: _____

(Street # Ins. Phone #)

(City, State) (Zip Code)
 Insurance ID# _____ Group#: _____

Mother / Guardian

Name _____
 S.S.# _____ DOB _____
 Occupation _____
 Business Name _____
 Business Location _____
 If different from patient:
 Home address _____
(Street #)

(City, State) (Zip Code)
 Home Phone () _____

Father / Guardian

Name _____
 S.S.# _____ DOB _____
 Occupation _____
 Business Name _____
 Business Location _____
 If different from patient:
 Home address _____
(Street #)

(City, State) (Zip Code)
 Home Phone () _____

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Comfort Kids on any unpaid bills for services furnished me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

CERTIFICATION AND CONSENT FOR TREATMENT OF A MINOR

I certify that the above information is correct and I hereby authorize the doctors to use such measures as deemed necessary in their professional judgement to render a diagnosis for my child. This would include an oral examination including any necessary X-rays and after an explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until cancelled by either party.

Signature _____ Relationship to child _____ Date _____